Date:

MAC Pricing Appeal Form

Appeals must be submitted within 30 days or within such time period as may be required by applicable state law, of the claim fill date.

Please complete the form and fax to 1-866-285-8652

All fields are required - Incomplete forms will not be reviewed

Provider Information:

Pharmacy/Provider Name:

Pharmacy/Provider NCPDP ID: Pharmacy/Provider NPI:

Contact Name:

Phone Number: Fax Number to send response:

E-mail:

Member Information:

Last Name: First Name:

Member ID: Middle Initial:

Rx Number: Date of Birth:

Claim Information:

Claim Authorization Number: ☐ Brand ☐ Generic

BIN: PCN: Submitted Group:

NDC: Claim Fill Date: Qty

Dispensed Product Name:

Invoice Price: Product Strength: Drug Form:

Comments:

MUST submit invoice showing NDC of the claim being disputed with this form

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